Objectives A problem with the approach of Evidence-based Medicine (EBM) is the current ability to only reduce but not prevent overdiagnosis. Overdiagnosis is broadly defined as ‘making people patients unnecessarily, by identifying problems that were never going to cause harm or by medicalising ordinary life experiences through expanded definitions of diseases’. One aspect of overdiagnosis is overdefinition, such as lowering the threshold for treatment for a risk factor. A current example is the UK’s National Institute for Health and Care Excellence (NICE) updated draft guidance for the diagnosis and management of hypertension in adults. The recommendations in the guidance are not evidence based and will increase overdiagnosis. However, EBM would be insufficient to avoid overdiagnosis even if this NICE guidance followed the principles. The objective of this study is to show why EBM is insufficient to avoid over diagnosis.

Method This study analyse the NICE draft guidance by the principles of following EBM guidance: Users’ Guides to the Medical Literature by (Guyatt et al), Guidance for modifying the definition of diseases: A checklist (Doust et al), and EBM manifesto for better healthcare (Heneghan et al). The principles of these analyses are what the consequences would have been if the NICE guidance had followed these principles. The principles and consequences are then analysed for their epistemological and ontological properties to determine what kind of scientific theory that leads the current EBM.

Results EBM do not sufficiently assess the ontological aspect of a diagnosis. In the case of the NICE guidance, the ontological status of hypertension is primarily as a risk factor. A risk factor of such is a continuum with no clear boundary between normal (health risk small enough to be accepted) and pathological (health risk unacceptably high). Therefore, the diagnosis of hypertension is subject to the problematic sorites paradox. The original puzzle, from 400 BCE, is: how many grains of sand have to be removed from a heap before we no longer have a heap? In this case, when a risk factor is accepted as a disease, followed by the consequence of overdiagnosis.

Conclusions Due to lack of ontological awareness and epistemological dominance, the current EBM approach does not sufficiently address overdiagnosis. Increase awareness of ontological aspects is necessary. The NICE guidance for hypertension provides a good basis for a much-needed discussion about what possible ontological solutions could bring us closer to limiting overdiagnosis via EBM.
Conclusions The MEWS independently predicts the likelihood of MICU readmission. Since the MEWS score can be automatically generated by the EHR it is prudent for clinicians to use it for frequent monitoring of patients during the first 72 hours of their discharge from the intensive care unit.

Method We used electronic health record data from UK primary care to design a prototype communication aid: a table and explanatory text showing how eGFR values map to bands of ‘kidney age’, and the increasing CVD risk at each band of kidney age. The design and content were refined iteratively in consultation with patient-public involvement representatives. UK general practitioners were then interviewed about the proposed design and content.

Results Interviews are ongoing but results to date suggest that GPs would welcome ‘kidney age’ terminology and our communication tool, possibly modified, as a potential intervention.

Conclusions A web-based version of the communication aid is currently under development, that can be tested as an intervention in a future parallel-group trial.

Objectives In modern philosophy, the concept of truth has been problematized from different angles, yet in evidence-based health care (EBHC), it continues to operate hidden and almost undisputed through the linked concept of ‘bias.’ To prevent unwarranted relativism and make better inferences in clinical practice, clinicians may benefit from a closer analysis of existing assumptions about truth, validity, and reality. Here we give a brief overview of several important theories of truth, notably the ideal limit theorem (which assumes an ultimate and absolute truth towards which scientific inquiry progresses), the dominant way truth is conceptualized in the discourse and practice of EBHC.

Method We draw on Belgian philosopher Isabelle Stengers’ work to demonstrate that bias means one thing if one assumes a world of hard facts ‘out there,’ waiting to be col- lected. It means something different if one takes a critical view of the knowledge-power complex in research trials. Bias appears to have both an unproductive aspect and a productive aspect as argued by Stengers and others: Facts are not absolute but result from an interest, or interesse: a bias towards a certain line of questioning that cannot be eliminated.

Results The duality that Stengers’ view invokes draws attention to and challenges the assumptions underlying the ideal limit theory of truth in several ways. Most impor- tantly, it casts doubt on the ideal limit theory as it applies to the single case scenario of the clinical encounter, the cornerstone of EBHC. To the extent that the goal of EBHC is to support inferencing in the clinical encounter, then the ideal limit as the sole concept of truth appears to be conceptually insufficient.

Conclusions We contend that EBHC could usefully incorporate a more pluralist understanding of truth and bias and provide an example how this would work out in a clinical scenario.

Objectives Previous research shows that the terminology ‘chronic kidney disease’ (CKD) is problematic for both patients and general practitioners, arguably because it repre- sents an ageing process rather than a disease. We have previ- ously proposed an alternative terminology ‘kidney age’ to supersede the terminology of CKD stages 2, 3a, 3b and 4. We aim to develop a communication tool that can be used to discuss declining kidney function with patients without using the terminology of ‘disease’.

Method We used electronic health record data from UK primary care to design a prototype communication aid: a table and explanatory text showing how eGFR values map to bands of ‘kidney age’, and the increasing CVD risk at each band of kidney age. The design and content were refined iteratively in consultation with patient-public involvement representatives. UK general practitioners were then interviewed about the proposed design and content.

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